DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. BUILDING _____ B. WING _____	09/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCREARY HEALTH AND REHABILITATION	58 CAL HILL ROAD PINE KNOT, KY 42635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 30-September 1, 2010. Deficient practice was identified with the highest scope and severity being at an "E" level.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dawn Baird RN. D.O.N. 10/4/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse were immediately reported to officials in accordance with state law. The facility also failed to ensure that the results of all investigations were reported to state agencies in accordance with state law. An allegation of abuse involving resident #7 was reported to Facility Administration; however, the facility failed to report the allegations to state agencies. The findings include: An interview with the Ombudsman on August 30, 2010, at 8:30 a.m., revealed the Facility Administrator had requested the Ombudsman talk to residents #7 and #11. Resident #11 had reported to the Administrator that resident #11's roommate, resident #7, was being abused by the staff. The Ombudsman stated he/she received the call from the Administrator on Friday, August 27, 2010. A review of the facility's investigation of the allegation revealed the Facility Administrator and the Social Worker conducted an investigation into the allegation and concluded that the allegation was unsubstantiated. A review of the medical record for resident #11	F 225	9/16/10 Allegations from Resident #11 were called to Adult Protective Services on 8/31/10 and investigated by survey team on 9/01/10. After review of all abuse allegations it was determined that no other residents were found to be affected by the deficient practice. Any further allegations will be phoned to the Department of Community Services and Division of Long Term Care immediately. Any further allegations will be investigated by Administrator or D.O.N. with a copy of the completed Final Report/Investigation of Suspected Abuse being submitted to the Department of Community Based Services and Division of Long Term Care within five (5) working days. Upon receiving initial complaint Senior Vice President of Clinical Services will be contacted to ensure compliance. An Allegation/Abuse log will be maintained in the Administrators office where a copy of the completed form will be logged. These will be reviewed quarterly by QA.	

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F 225	Continued From page 2 (complainant) revealed a quarterly Minimum Data Set (MDS) completed on July 7, 2010. The MDS Coordinator assessed resident #11 to have an intact long/short-term memory, to be independent with decision-making ability, was able to understand others, and was understood by others. An interview was conducted with resident #11 on September 1, 2010, at 2:00 pm. Resident #11 stated he/she overheard staff members being sexually inappropriate with his/her roommate. Resident #11 stated he/she had no concrete proof of the sexual misconduct but the staff's behavior was morally wrong. Resident #11 refused to name the staff involved/dates the incidents occurred. Resident #11 stated he/she reported the incident(s) on August 21, 2010, to the Facility Administrator. Resident #11 stated he/she felt confident the Facility Administrator would investigate/deal with the alleged staff members appropriately. A review of the facility's abuse/neglect policy revealed if an incident was determined (at least initially) to be "suspected abuse" the incident was to be reported to the Department for Community Based Services and the Division of Health Care. An interview with the Facility Administrator conducted on August 31, 2010, at 10:00 a.m., revealed resident #11 made an allegation on August 21, 2010, and the Administrator initiated an investigation. The Administrator stated the allegation was quickly unsubstantiated. The Administrator further stated he/she was unaware the state agencies were to be notified if the allegation was unsubstantiated or that the results of the facility investigation were to be forwarded to	F 225		

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F 225	Continued From page 3 state agencies within five days.	F 225		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A and B Hall medication carts were observed to be soiled, wallpaper in resident rooms was loose and torn, doors to resident rooms and shower rooms were chipped exposing splintered wood, baseboard in resident rooms was loose, and a buildup of dust was in fans. The findings include: 1. Observation of the facility during the environmental tour on August 31, 2010, at 9:30 a.m., revealed the following items were in need of repair/cleaning: -Torn/loose wallpaper was observed in rooms A-1, B-6, C-12, and C-1; -Chipped/splintered doors were observed in rooms A-6, A-8, A-9, A-10, B-5, B-8, C-2, C-5, and the doors to both shower rooms; -Loose baseboards were observed in rooms A-11, B-2, B-5, and B-7; -Fans on the A Hall and C Hall were observed to have a buildup of dust.	F 465	9/27/10 #1 No residents were indentified. On 9/07/10 Maintenance Supervisors monthly checklist was updated to include torn/loose wallpaper, chipped/splintered doors, loose baseboards, and build up of dust on A hall and C hall fans. All items were repaired or replaced by Maintenance department on 9/27/10. Maintenance Supervisor and Housekeeping Supervisor will do a monthly walk thru within the first seven (7) business days of each month with a written report provided to the Quality Assurance committee at the monthly QA meeting.	

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F 465	Continued From page 4 Interview conducted on September 1, 2010, at 1:00 p.m., with the Maintenance Supervisor (MS) revealed maintenance request sheets were documented on a work summary log and requests were addressed when they were received. In addition, staff would inform the MS of any items in need of repair. The MS was not aware of the items in need of repair or cleaning. 2. Observations of A and B Hall medication carts conducted on September 1, 2010, at 1:30 p.m., revealed the carts had a buildup of dirt and debris on the bottom edges of the carts and a buildup of medication residue in the medication drawers. An interview conducted with the Director of Nursing on Sept 1, 2010, at 1:45 p.m., revealed the medication carts were required to be cleaned weekly by the night shift. However, the facility had no system for ensuring the carts were cleaned and no documented evidence the carts were cleaned.	F 465	No residents were affected. On 9/16/10. All medications carts were inspected and cleaned by D.O.N. Medication carts will be cleaned weekly by 7PM – 7 AM shift with log to be maintained by the D.O.N. Medication carts will be inspected by D.O.N and A.D.O.N on a monthly basis.	
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that handrails were firmly secured to the wall in resident bathrooms on the B and C hallway. The findings include:	F 468	No residents were indentified. On 9/07/10 Maintenance Supervisors monthly check list was updated to include inspection of handrails. All handrails were inspected and repairs, as needed, completed on 9/10/10. Maintenance Supervisor and Housekeeping Supervisor will do a monthly walk thru within the first seven (7) business days of each month.	9/10/10

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F 468	Continued From page 5 An environmental tour conducted on August 31, 2010, at 9:30 a.m., revealed loose handrails in the resident bathrooms located in rooms B-1, B-2, and C-12. An interview conducted with the Maintenance Supervisor (MS) on September 1, 2010, at 1:00 p.m., revealed the MS was not aware of the loose hand rails. Further interview revealed that the handrails loosened due to the mounting of the bars in the drywall.	F 468		